10/06/2011 PRINTED: FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G797		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/12/2011		
NAME OF I	PROVIDER OR SUPPLIER		902	EET ADDRESS, CITY, STATE, ZIP CODE 19 S AMERICA ROAD FONTAINE, IN46940	-	
(X4) ID PREFIX TAG W0000	This visit was for th #IN00095983. Complaint #IN0009 Federal and state de allegations are cited W149, W153, W154 Unrelated deficience Dates of Survey: Se FACILITY NUMBE PROVIDER NUME AIM NUMBER: 20 Surveyor: Susan EIII/QMRP These federal deficienting in accordance of the second o	eptember 8, 9, and 12, 2011. ER: 0012563 BER: 15G797 01018540 akright, Medical Surveyor encies also reflect state ace with 431 IAC 1.1. apleted 9/19/11 by Ruth	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
W0102	governing body ar requirements are i Based on observatio interview, the Cond	-	W0102	W 102 Governing Body Management The survey problems associated with reported incidents and the follow-up actions. These	cited eir	10/12/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

012563

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G797	B. WIN			09/12/2011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	R.			AMERICA ROAD	
AWS					ITAINE, IN46940	
AVVO				LATON	ITAINE, IN40940	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	3 of 3 sampled clier	nts (clients A, B and C). The	1		late reporting of allegations of	of
	governing body fail	ed to establish operating			abuse by direct-care staff, la	te
		acility to ensure the Conditions			incident reporting by profess	ional
		ent Protections (clients A, B,			staff, poor corrective follow-u	ıp,
	-	Care Services (clients B and C)			lack of thorough investigating	g,
	· ·	erning body failed to ensure			and poor implementation of	
	_	he agency's policy and			treatments, including medica	tion
	*	, neglect, and mistreatment			administration and preventio	n of
	prevention, failed to				aggressive behavior. Correct	ctive
		ed incidents of abuse, neglect,			action for resident(s) found	to
		nd failed to ensure thorough			have been affected The Age	ency
		completed. The governing			will implement a number of	
		re implementation of effective			different measures to addres	s the
		protect clients from physical			problems and to prevent	
		and/or mistreatment			recurrence. There will be	
		governing body failed to			trainings conducted with both	
		versight of the group home to			direct-care and professional	
		s, routine maintenance, staff			to address cited deficiencies	
	_	ication administration.			There will be a new process	
	, , , , , , , , , , , , , , , , , , , ,				implemented to address	
	Findings include:				medication errors. There als	o will
					be new competency-based	
	Please see W104 T	The governing body failed for 3			training procedures put in pla	ace to
		(clients A, B, and C) to ensure			improve implementation of	
	_	heir abuse, neglect, and			treatments. Finally, there will be	
	_	and procedure to manage			a new committee that will ho	
		physically aggressive			weekly meetings to evaluate incident reports and	
	behaviors, failed to				investigations to ensure they	were
	·	ed allegations of abuse, failed			thorough and that follow-up	*****
		ed corrective action was			corrective actions are	
		t clients from their identified			appropriately designed to pre	event
		d to ensure thorough			recurrence. Additional details	• • • • • • • • • • • • • • • • • • •
		completed. The governing			these corrective actions are	
	_	de oversight over the group			provided throughout this Plan	n of
	home staff in regard				Correction. How facility will	
	_	behavior management,			identify other residents	
		tration errors, and routine			potentially affected & what	
		enclosure doors for client A			measures taken All resident	s
	and B's bedrooms.				affected, and measures take	I
					address the needs of all clier	
			L			

li '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G797		B. WING			011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹					
1110			1	AMERICA ROAD			
AWS				LAFON	ITAINE, IN46940		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	Please refer to W12	2. The governing body failed			the home. Measures or		
		on of Participation: Client			systemic changes facility p	ut in	
		f 3 sample clients (clients A, B,			place to ensure no recurrer		
		ing body neglected to			An Incident Oversight Comm		
		ise, neglect, and mistreatment			will be established consisting		
		re, to immediately report			the agency's Vice President,	-	
		/mistreatment, physical			Regional Director, and		
		dication errors to the			Compliance Officer. This		
		ding to state law; to complete			committee will hold a		
		ions, to take effective			documented weekly meeting	ı in l	
		protect clients A, B, and C			which all Incident Reports ar		
		d behaviors; and to prevent			Investigations from the previ		
	client to client phys	-			week are reviewed for		
	chefit to effent phys	icai aggiession.			appropriate action to resolve	the	
	Dlagge refer to W21	8. The governing body failed			immediate incident, adheren		
		0 0			agency policy, and follow-up		
		on of Participation: Health			actions to prevent recurrence		
		ne facility's failure to provide			When needed, recommende		
		e monitoring and oversight of			corrective actions will be		
		tration for 2 of 3 sample clients			communicated to the resider	nts'	
	(clients B and C).				IDT within one day to be		
	TEN : 0 1 1 1 1				addressed within one week.	Each	
	This federal tag rela	ites to complaint			committee meeting will begir	n with	
	#IN00095983.				a review of the status of		
	1121()				recommended corrective act	ions	
	1.1-3-1(a)				from the previous week. H	ow	
					corrective actions will be		
					monitored to ensure no		
					recurrence House Manager		
					supervises staff and ensures	;	
					proper training. The Behavio	or	
					Clinician revises BSP proced	dures	
					and implements training,		
					including the new		
					competency-based procedur	es	
					being put into place. The		
					Regional Director supervises		
					professional staff and ensure	es	
					their training. The Incident		
					Oversight Committee is chai		
					by the Compliance Officer w	ho is	
					operationally and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G797	B. WING		09/12/2011
NAME OF F	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE	
THE OF I	NO VIDEN ON SOIT EIEN		9029	S AMERICA ROAD	
AWS			LAFO	ONTAINE, IN46940	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	programmatically distinct fro	DATE
				facility. The Chair will ensure smooth and continuous oper of the committee. W 102 In the smooth and continuous oper of the committee. W 102 In the smooth and the smooth a	ration Detail Abuse, dents. Deen on late
				reporting of all allegations. Professional staff will receive training on Agency Policy. facility will identify other residents potentially affect	How
				what measures taken All residents affected, and correaction will address the need all clients in the home.	ective
				Measures or systemic char	_
				facility put in place to ensu	
				no recurrence In addition to	
				staff member who reported to	• • • • • • • • • • • • • • • • • • •
				allegation late, all other staff members in the home will be	• • • • • • • • • • • • • • • • • • •
				trained about the requireme	·
				immediately report all	
				allegations. Professional sta	.
				receive training on Agency p	
				An Incident Oversight Comn	nittee
				will be established. How	
				corrective actions will be	
				monitored to ensure no	
				recurrence House Manager	.
				supervises staff and ensured proper training. The Region Director supervises professions at the control of the	nal onal
				staff and ensures their traini The Incident Oversight	ng.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UFRV11 Facility ID: 012563

If continuation sheet

Page 4 of 56

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/12/2011
NAME OF F	PROVIDER OR SUPPLIER	!!	STREET A 9029 S	ADDRESS, CITY, STATE, ZIP CODE AMERICA ROAD ITAINE, IN46940	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
				Committee will review all In Reports and Investigations determine if appropriate actions at taken to resolve the immediate incident, whether actions adhered to agency and will evaluate if sufficient follow-up actions to prever recurrence are put in place 102 Detail #2 Implementing Policy on Abuse, Neglect, Mistreatment - Thorough Investigations. Corrective action for resident(s) four have been affected All professional staff members responsible for investigations trained on both the Age policy as well as how to conthorough investigations. If acility will identify other residents potentially affer what measures taken All residents affected, and confaction will address the neer all clients in the home. Measures or systemic charcility put in place to ensure no recurrence Training will completed, and an Incident Oversight Committee will be established. How correct actions will be monitored ensure no recurrence The QDDP conducts investigat supervised by the Regional Director. The Regional Staincluding ensuring training requirements are met. The Incident Oversight Committee The Incident Oversigh	er policy, not set on the set on

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	(X2) MULTIPLE CO: A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI 09/12/2	LETED
	ROVIDER OR SUPPLIER		9029 S	DDRESS, CITY, STATE, ZIP CODI AMERICA ROAD TAINE IN46940	3	
NAME OF PAWS (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	STREET A 9029 S		to action ether vent place. We tive ective ound to ident ill be tive dent ens. How er ffected & All corrective needs of changes ensure meeting promittee nendations actions. It is will be to the change of the chan	(X5) COMPLETION DATE
				smooth and continuous	operation 102 rematic nt rights, aff	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	A. BUILDING B. WING	00	COMPI 09/12/2	LETED
NAME OF P	ROVIDER OR SUPPLIER		STREET A 9029 S	ADDRESS, CITY, STATE, ZIP CODE AMERICA ROAD NTAINE, IN46940	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
				administration errors. Corrective action for resident(s) found to hav affected Incident Oversig Committee will be establi ensure implementation or effective corrective action incident reports and investigations. Regional will continue to hold regumeetings with profession Client Rights, Routine Maintenance, Staff Retran Needs, & Medication Administration / Medication affected & what measure taken All residents affect corrective action will addineds of all clients in the Measures or systemic of facility put in place to en no recurrence Establish Incident Oversight Committed Routine Maintenance, Staff Retraining Needs, & Medication on agenda. How corrective action will addined to oversight Committed Needs of all clients in the Measures or systemic of facility put in place to en no recurrence Establish Incident Oversight Committed Needs, & Medication on Administration (Medication on agenda). How correct actions will be monitore ensure no recurrence Tillincident Oversight Committed by the Complian Officer who is operational programmatically distinct facility. The Chair will ensmooth and continuous of the committee. The Resident Committee Committee. The Resident Committee. The Resident Committee Committee. The Resident Committee Committee. The Resident Committee Committee. The Resident Committee Committee Committee. The Resident Committee Committee Committee. The Resident Committee Co	shed to f n for Director lar al staff. ining on Errors agenda identify illy es ed, and ress the home. hanges ment of nittee; f at Rights, aff lication on Errors etive ed to he nittee is ce lly and from the sure the operation	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	A. BUILDING 00 COM			ETED
		15G797	A. BUILDING 00/12/201			₀₁₁	
			B. WIN		ADDRESS STATE STATE STATE		
NAME OF P	ROVIDER OR SUPPLIER	-		l	ADDRESS, CITY, STATE, ZIP CODE		
4140				1	AMERICA ROAD		
AWS				LAFO	NTAINE, IN46940		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Director supervises profession staff and will continue to chain meetings that now will include added items on the agenda.	ir	
W0104		dy must exercise general d operating direction over					10 (10 (2011
			W	0104	W 104 Detail #1 Implementin	- 1	10/12/2011
		on, record review, and			policy. Corrective action for		
		sample clients (clients A, B,			resident(s) found to have be affected Staff member who	∍en	
		ng body failed to ensure			reported allegation late will b	_	
	-	heir abuse, neglect, and and procedure to prevent			trained on need to immediate		
		physically aggressive			report all allegations. All stat		
	behaviors, failed to				members in home will receive	e	
		d allegations of abuse, failed			training on need to report		
		ed corrective action was			immediately. Professional sta		
	completed to protect	t clients from their identified			will receive training on agenc		
	behaviors, and failed	d to ensure thorough			policy. Regional Director will continue to hold regular mee		
	_	completed. The governing			with professional staff with a		
		de oversight of the facility in			agenda items including Clien		
	-	g staff interactions during			Rights and Staff Retraining		
		nt, medication administration			Needs. How facility will		
	doors for client A an	eplacement of fire enclosure			identify other residents		
	doors for effett A an	ld B's bedrooms.			potentially affected & what		
	Findings include:				measures taken All residents	-	
					affected, and corrective action		
	1. The facility's BD	DS (Bureau of Developmental			address the needs of all clier	its in	
	-	reports from 7/1/11 through			the home. Measures or		
		ed on 9/7/11 at 11:20am and			systemic changes facility p place to ensure no recurren		
	indicated the follow	ing with no injuries			Training of staff members wit		
	documented:				oversight by agency. Regula		
					meetings of professional staf		
	For client A:				with new focus in meetings.		
	DDDG	20/11 :: 1 0/20/11			How corrective actions will	be	
	-	30/11 incident on 8/29/11 at			monitored to ensure no		
	_	ts A, B, and C made an			recurrence House Manager		
		irect Care Staff (DCS) #4, #5, elling, and giving the clients			supervises staff, including		
	and #0 101 mumg, y	ching, and giving the chems			ensuring appropriate training		

l í		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G797	B. WIN	в. WING 09/12/2011		
NAME OF F	DOLUDED OD GUDDU IED		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE	l .
NAME OF F	PROVIDER OR SUPPLIER			9029 S	AMERICA ROAD	
AWS				LAFON	ITAINE, IN46940	
(X4) ID	SHWWADVS	TATEMENT OF DEFICIENCIES	_	ID	<u> </u>	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
IAG		up home. The 8/30/11 QMRP	-	IAG	The Regional Director super	
		etardation Professional)			professional staff and will	VISCS
	investigation results	· · · · · · · · · · · · · · · · · · ·			continue to chair meetings th	nat
	-	ction was recommended to be			now will include added items	•
	taken. The 8/30/11				the agenda. W 104 Detail	
		A and B did not actually view			Preventing aggressive behave	•
		and #6 hit another client;			Corrective action for	
		s A and B continued to state to			resident(s) found to have b	een
	the QMRP that staff	#4, #5, and #6 yelled at			affected All staff members in	
	clients in the group	home and continued to give			home will receive retraining to	
	the clients cigarettes	to encourage the clients to			certified trainer in appropriate	e
	smoke.				de-escalation and physical	
					intervention procedures. So	
	•	22/11 incident 8/20/11 at 7pm,			additional measures are beir added to client BSPs to addr	·
		with client C in kitchen, and an			problem behavior earlier in the	
		epped between clients A and C.			chain in order to try to preven	•
	-	client A attacked the staff			escalation to physical	
	_	applied a physical mandt hold			aggression. New	
	for three (3) minutes	S.			staff-competency testing	
	RDDS report on 8/	4/11 incident 8/2/11 at			procedures are being put into	0
	_	lient A witnessed client C push			place for BSP training. How	V
		report indicated client A			facility will identify other	
		ggressive toward client C and			residents potentially affecte	ed &
		f applied a one (1) arm mandt			what measures taken All	
	hold for three (3) mi	**			residents affected, and corre	
	,				action will address the needs	S OT
	-BDDS report on 7/2	29/11 incident 7/28/11 at 5pm,			all clients in the home.	
	indicated client A go	ot verbally and physically			Measures or systemic char facility put in place to ensu	- 1
	aggressive with clien	nt C after the dietician "gave			no recurrence Training of st	•
		riticism" at the dining room			members on de-escalation a	•
		out of the group home with			appropriate physical	
	•	then attacked staff, returned to			management. BSP modificat	tions
		attacked client C and bit her			to try to prevent behavioral	
	on the head.				escalation. New	
					competency-based training	
		18/11 for an incident which			method put in place for both	initial
		7/17/11 at 8pm, indicated a			training as well as on-going	
	~	s A, B, and C with 3 staff			competency testing. How	
	uying to separate the	em. The report indicated			corrective actions will be	
					<u> </u>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G797 09/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9029 S AMERICA ROAD **AWS** LA FONTAINE, IN46940 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 9-1-1 was called by client D on the phone. Mandt monitored to ensure no restraints were applied to clients A, B, and C by recurrence House Manager the staff until calm. supervises staff, including ensuring appropriate training. The Behavior Clinician revises -BDDS report on 7/18/11 incident 7/16/11 at 4pm, BSP procedures and implements indicated client A became upset and hit client C. Client A left AWOL with staff following her. The training, including the new competency-based procedures report indicated client A had mandt restraints being put into place. W 104 applied by the facility staff, calmed, and returned Detail #3 Ensuring staff to the group home. immediately report allegations of abuse Corrective action for Eight (8) additional BDDS reports for incidents on resident(s) found to have been 9/4/11 at 6pm, on 9/3/11 at 9pm, on 8/15/11 at affected Staff member who 2pm, on 8/10/11 at 8pm, on 8/9/11 at 6pm, on reported the abuse allegation late 8/9/11 at 8pm, on 7/19/11 at 6pm, and on 7/17/11 will receive training on prompt at 9:30am, for client A which involved the mandt reporting of all allegations. restraints for Physical Aggression and client A's Professional staff will receive AWOL behavior were documented with no training on Agency Policy. How corrective action documented and no follow up to facility will identify other determine the effectiveness of client A's plans. residents potentially affected & what measures taken All For client B: residents affected, and corrective action will address the needs of -BDDS report on 7/15/11 incident 7/14/11 at all clients in the home. 8:30am, indicated client B woke up upset and Measures or systemic changes wanted to choose her own breakfast. The report facility put in place to ensure indicated the unidentified staff redirected client B no recurrence In addition to the multiple times. Client B became physically staff member who reported the aggressive toward staff, client B banged her head allegation late, all other staff and bit herself. Client B left the area then returned members in the home will be with a bottle of tea which she swung and hit the trained about the requirement to staff. The report indicated client B had a Mandt immediately report all one arm restraint applied from behind for one (1) allegations. Professional staff will minute. Client B dropped to the floor, and began receive training on Agency policy. to bang her head and kicked staff, mandt restraint An Incident Oversight Committee again applied for 3 minutes. will be established. How corrective actions will be -BDDS report on 7/11/11 incident on 7/9/11 at monitored to ensure no 10am, indicated client B woke up upset. Client B recurrence House Manager began to bite herself, swung and hit the staff, and supervises staff and ensures

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
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		15G797	B. WIN	IG		09/12/2	011
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(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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	areas of the skin.				of the committee. W 104		
					Detail #5 Ensuring thorough		
		4/11 incident 8/2/11 at 4pm,			investigations Corrective a		
		vas attacked by client A and			for resident(s) found to have		
		on the head. Then client C			been affected All profession		
		f. The report indicated the			staff members responsible for		
		d a one (1) arm mandt restraint			investigations will be trained		
		The report indicated less than			both the Agency policy as we	ell as	
		ent C pushed staff out of her			how to conduct thorough		
		er head, staff applied a one (1)			investigations. How facility	will	
	arm mandt restraint for one (1) minute.				identify other residents		
					potentially affected & what		
		/18/11 incident on 7/16/11 at			measures taken All resident	·	
		nt A "attacked" and hit client C			affected, and corrective action		
	twice, once in back and once in head. No corrective action was documented.				address the needs of all clier	nts in	
					the home. Measures or		
					systemic changes facility p		
	1	DDS (Bureau of Developmental			place to ensure no recurrer		
		reports from 7/1/11 through			Training will be completed, a		
		ed on 9/7/11 at 11:20am and			an Incident Oversight Comm	ittee	
		ving for documented			will be established. How		
	medication errors:				corrective actions will be		
					monitored to ensure no		
	For client B:				recurrence The QDDP cond		
					investigations supervised by		
		/1/11 medication error incident			Regional Director. The Region		
		icated client B complained of			Director supervises profession		
	`	breath) dx COPD (diagnosis			staff, including ensuring train	iing	
		e Pulmonary Disease)." The			requirements are met. The Incident Oversight Committe	ا بانید	
	1 *	ent B had a physician's order			review all Investigations to	e wiii	
		er day. Client B told staff she			determine if appropriate action	n	
		f. The report indicated staff			was taken, including whethe		
		medication without checking			follow-up actions to prevent	'	
		d client B exhibited SOB. The			recurrence were put in place	_	
		ff did not follow client B's			W 104 Detail #6 Providing	·	
		The report indicated the Advair			oversight regarding (a) staff		
		ed medication. The report			interactions during behavior		
		came to the group home and			management, (b) medication	,	
		it to her physician for an office			administration, and (c) broke		
	visit. No corrective	e action was documented.			door replacement Correcti		
						-	

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NAME OF I	PROVIDER OR SUPPLIER			9029 S	AMERICA ROAD		
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		,			action for resident(s) found	to	
	-BDDS report on 7/	21/11 for a medication error			have been affected (a) New		
		8am, indicated client B's			staff-competency testing		
		r Hypertension) was not given			procedures are being adopte	d for	
		cause staff neglected to read			initial training and ongoing		
		Administration Record) and			implementation of BSP		
		etraining." No documented			procedures. This is over and	ı l	
		ng was available for review.			above the Mandt de-escalati		
		20 a.5 a valido lo 101 10 vie vi.			and physical intervention trai		
	-BDDS report on 7/	/18/11 for a medication error			that already involves staff	-	
		at 12pm, indicated client B			competency testing; (b) Agei	ncy	
		on 7/7/11. A new medication			Nurse is implementing a new	,	
	Losartan HTCZ 1 time daily was started and the				"dot" medication administrati	on	
		ued the Lasix medication. The			method that gives staff a way	/ to	
		m 7/7/11 through 7/17/11 client			check their work and enhand		
		x med and no Losartan			accuracy with each pill popper		
	medication. No con				represented by a dot on the		
	documented.	Toolare delicate was			so they count dots and pills t		
	documentou.				ensure they match up; and w		
	For client C:				continue with "buddy checkir		
	101 0110111 01				where the staff member pass	-	
	-No written BDDS	report for medication error			medication is checked by an		
		d on 8/1/11, no time			staff person; (c) Replacemen		
		eport indicated client C missed			doors were repaired so that t	-	
		on because the pharmacy			close properly. How facility identify other residents	wiii	
		n to refill and was waiting for			potentially affected & what		
		nformation in regards to the			measures taken All resident	_	
		which was being ordered for			affected, and corrective action		
		ole for review. No corrective			address the needs of all clier		
	action was docume				the home. Measures or		
					systemic changes facility p	ut in	
	On 9/7/11 from 1:2	0pm until 2:50pm, observation			place to ensure no recurrer		
	and interviews were	e completed at the group home.			(a) New staff-competency		
	At 1:50pm, client A	indicated she did not see a			procedures will ensure corre	ct I	
	facility staff hit ano	ther client. Client A stated she			implementation of BSP		
	had seen "staff hit"	and "tell us to smoke			procedures. (b) New "dot"		
	cigarettes." Client	A indicated she had told a staff			method is being adopted to		
	about this on 8/30/1	1 in the morning. Client A			enhance accuracy of medica	tion	
	stated "They gave n	ne cigarettes, but I was told not			administration. (c) A new		
	to talk about it." At	t 1:55pm, client C stated she			"handyman" has been retain	ed to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MU AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/12/2011
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797		(X2) MU: A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 09/12/20	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	B. WING	STREET A 9029 S A	DDRESS, CITY, STATE, ZIP CODE AMERICA ROAD TAINE, IN46940		
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TAG	systematically woul abuse/neglect. The implementation of the prohibit abuse, neglether of the prohibit abuse, neglether of the facility did not head	d protect the clients from facility neglected to ensure heir policy and procedures to ect, and mistreatment. In, an interview with the Site completed. The SD indicated have documentation for clients on physically aggressive and andt physical holds to prevent physical aggressive behaviors. To documented evidence was to indicate the facility dincidents for patterns, and we action after each incident. He clients' programs, and no diately reporting of incidents view. The SD indicated the facility did nort allegations of abuse, ment and should have bed to the administrator and to state law. The SD indicated have documented oversight of of the agency's policy and perform none were available for the sumented corrective measures and none were available for the At 2:40pm, DCS (Direct Care at A was "missing [client A's] out a month and [client B] no		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CC	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G797	B. WING		09/12/2011
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		ver two (2) weeks." DCS #1			
		s were "broken off at the			
	_	A and B "were trying to walk luring their behaviors.			
	unough the doors of	during their behaviors.			
	On 9/12/11 at 11:20a	am, an interview with the SD			
		indicated the doors were up			
		ime but that the doors did not			
		e SD indicated client A and B's			
	bedroom doors were to latch shut at this t	e fire doors and did not close			
	to fatch shut at this t	ime.			
	This federal tag rela	tes to complaint			
	#IN00095983.	•			
	1.1-3-1(a)				
W0122	The facility must e	nsure that specific client			
., 0122	protections require				
			W0122	W 122 Detail #1 Implementii	ng 10/12/2011
	Based on observatio	n, interview, and record		Policy on Abuse, Neglect, &	
	review for 3 of 3 sar	nple clients (clients A, B, and		Mistreatment - Immediate	
		d to meet the Condition of		Reporting of Incidents.	
		t Protections. The facility		Corrective action for	
		ent their abuse, neglect, and		resident(s) found to have b affected Staff member who	een
	report incidents of a	and procedure, to immediately		reported the abuse allegatio	n late
	•	and physical aggression to the		will receive training on prom	
		cording to state law; to		reporting of all allegations.	
		nvestigations, to take		Professional staff will receive	
		corrective action to protect		training on Agency Policy. F	low
		from their identified behaviors;		facility will identify other	ad 8
	and to prevent client	to client physical aggression.		residents potentially affect what measures taken All	eu o
	Eindings in 1 1			residents affected, and corre	ective
Findings include:			action will address the need	l l	
	Please refer to W149	9. The facility neglected to		all clients in the home.	
		se, neglect, and mistreatment		Measures or systemic char	- 1
	r	, <u> </u>		facility put in place to ensu	re

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G797 09/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9029 S AMERICA ROAD **AWS** LA FONTAINE, IN46940 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE policy and procedure to prevent client A, B, and no recurrence In addition to the C's physically aggressive behaviors, neglected to staff member who reported the allegation late, all other staff immediately report allegations of abuse, neglected members in the home will be to take immediate effective sufficient action to trained about the requirement to protect clients from their identified documented immediately report all behaviors, and neglected to complete thorough allegations. Professional staff will investigations for 3 of 3 sample clients (clients A, receive training on Agency policy. B, and C). An Incident Oversight Committee will be established. How Please refer to W153. The facility failed to corrective actions will be immediately report allegations of abuse, neglect, monitored to ensure no and mistreatment immediately and failed to recurrence House Manager immediately report client to client physical supervises staff and ensures aggression to the administrator and to BDDS proper training. The Regional (Bureau of Developmental Disability Services) in Director supervises professional accordance with state law for 3 of 3 sample clients staff and ensures their training. (clients A, B, and C) for 7 of 26 incidents reports The Incident Oversight reviewed from 7/1/11 through 9/7/11. Committee will review all Incident Reports and Investigations to Please refer to W154. The facility failed to determine if appropriate action thoroughly investigate client A, B, and C's was taken to resolve the allegations of abuse, neglect, and mistreatment for immediate incident, whether 3 of 3 sample clients (clients A, B, and C). actions adhered to agency policy. and will evaluate if sufficient Please refer to W157. The facility failed to take follow-up actions to prevent sufficient corrective action for documented recurrence are put in place. W incidents of physical aggression and multiple 122 Detail #2 Completing medication errors after a pattern had developed for thorough investigations. 3 of 3 sample clients (clients A, B, and C). Corrective action for resident(s) found to have been This federal tag relates to complaint affected All professional staff #IN00095983. members responsible for investigations will be trained on 1.1-3-2(a) how to conduct thorough investigations. How facility will identify other residents potentially affected & what measures taken All residents affected, and corrective action will address the needs of all clients in

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G797		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED - 09/12/2011			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA ROAD LA FONTAINE, IN46940				
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				the home. Measures or systemic changes facility place to ensure no recur Training will be completed an Incident Oversight Cowill be established. How corrective actions will be monitored to ensure no recurrence The QDDP or investigations supervised Regional Director. The Redirector supervises profestaff, including ensuring the requirements are met. The Incident Oversight Commerciew all Investigations the determine if appropriate a was taken, including whe follow-up actions to preverecurrence were put in place. W 122 Detail #3 Ensuring immediate implementation effective corrective action for resident(s) found to have affected Staff members were trained to immediately regallegations and peer-to-paggression to a supervised Professional Staff will rectaining on Incident Report Incident Oversight Commercial Developmentation of effective corrective action for incident Oversight Commercial Developmentation of effective corrective action for incident Oversight Commercial Developmentation of effective corrective action for incident Proportion of the Incidents affected, and contained to the Incidents of the Incidents affected, and contained to will address the new action action will address the new action action will address the new action action action	ry put in rrence d, and mmittee d, and mmittee d, e e e e e e e e e e e e e e e e e		

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

	F CORRECTION	IDENTIFICATION NUMBER: 15G797		LDING	00 	COMPL 09/12/2	ETED
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					all clients in the home. Measures or systemic char facility put in place to ensure no recurrence Staff training immediate reporting requirer Professional staff training on Incident Reporting; Weekly meeting of Incident Oversight Committee. How corrective actions will be monitored to ensure no recurrence House manager is responsible for a supervision, including training The Incident Oversight Committee is Chaired by the Compliance Officer who is operationally and programmatically distinct frofacility. The Chair will ensure smooth and continuous oper of the committee. W 122 Detail #4 Preventing aggres behaviors. Corrective action for resident(s) found to have been affected All staff members in the home will receive retrain appropriate de-escalation are physical intervention proced. Some additional measures a being added to client BSPs to address problem behavior ein the chain in order to try to prevent escalation to physical aggression. New staff-competency testing procedures are being put into place for BSP training. How facility will identify other residents potentially affects what measures taken All	on ment; ot e oe e taff g. m the e the ration sive on ve oers aining ad ures. are o arlier al	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UFRV11 Facility ID:

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Page 19 of 56

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	A. BUILDING B. WING	00	COMPLETED 09/12/2011
NAME OF I	PROVIDER OR SUPPLIER		STREET A 9029 S	ADDRESS, CITY, STATE, ZIP CODE AMERICA ROAD NTAINE, IN46940	
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W0149	written policies and mistreatment, neg Based on observation interview, for 3 of 3 and C), the facility rabuse, neglect, and raprocedure to preven physically aggressive immediately report to take effective sufffrom their identified	evelop and implement d procedures that prohibit lect or abuse of the client. n, record review, and sample clients (clients A, B, neglected to implement their mistreatment policy and t client A, B, and C's te behaviors, neglected to allegations of abuse, neglected ficient action to protect clients documented behaviors, and te thorough investigations.	W0149	residents affected, and corrective action will address the needs all clients in the home. Measures or systemic charactility put in place to ensure no recurrence Training of state members on de-escalation and appropriate physical management. BSP modificate to try to prevent behavioral escalation. New competency-based training method put in place for both training as well as on-going competency testing. How corrective actions will be monitored to ensure no recurrence House Manager supervises staff, including ensuring appropriate training. The Behavior Clinician revise BSP procedures and implementation training, including the new competency-based procedure being put into place. W 149 Detail #1 Immediate Reporting of Abuse Allegation Corrective action for resident(s) found to have be affected Staff member who reported the abuse allegations. Professional staff will receive training on prompreporting of all allegations. Professional staff will receive training on Agency Policy. If acility will identify other residents potentially affects what measures taken All	ges re aff aff and disions initial l. es aents res 10/12/2011 ns. een a late ot e. How

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UFRV11 Facility ID:

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Page 20 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S OO COMPL					
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AWS				LAFON	ITAINE, IN46940		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include:		ĺ		residents affected, and corre	ctive	
					action will address the needs	of	
	The facility's BDDS (Bureau of Developmental				all clients in the home.		
		reports from 7/1/11 through			Measures or systemic chan	-	
		ed on 9/7/11 at 11:20am and			facility put in place to ensu		
		ving with no injuries			no recurrence In addition to		
	documented:				staff member who reported the		
					allegation late, all other staff		
	For client A:				members in the home will be		
	555	(20/44: 14			trained about the requiremer immediately report all	וו נט	
		/30/11 incident on 8/29/11 at			allegations. Professional sta	ıff will	
4pm indicated clients A, B, and C made an					receive training on Agency p		
	allegation against Direct Care Staff (DCS) #4, #5, and #6 for hitting, yelling, and giving the clients cigarettes in the group home. The 8/30/11 QMRP				An Incident Oversight Comm		
					will be established. How		
		Retardation Professional)			corrective actions will be		
	1 ' '	s unsubstantiated the			monitored to ensure no		
	1	action was recommended to be			recurrence House Manager		
		QMRP investigation			supervises staff and ensures	;	
		A and B did not actually view			proper training. The Regiona		
		and #6 hit another client;			Director supervises profession		
	however both client	ts A and B continued to state to			staff and ensures their training	ng.	
	the QMRP that staff	f #4, #5, and #6 yelled at			The Incident Oversight	:	
	clients in the group	home and continued to give			Committee will review all Inc Reports and Investigations to		
	the clients cigarette	s to encourage the clients to			determine if appropriate action		
	smoke. No correcti	ve action was documented.			was taken to resolve the) i i	
					immediate incident, whether		
		/22/11 incident 8/20/11 at 7pm,			actions adhered to agency p	olicy,	
	"	with client C in kitchen, and an			and will evaluate if sufficient	•	
		epped between clients A and C.			follow-up actions to prevent		
		d client A attacked the staff			recurrence are put in place.	W	
	1 ^	applied a physical mandt hold			149 Detail #2 Protecting clien	nts	
	documented.	s. No corrective action was			from identified aggressive		
	documented.				behaviors. Corrective action		
	-RDDS report on 8	4/11 incident 8/2/11 at			for resident(s) found to hav		
		elient A witnessed client C push			been affected All staff memb		
		report indicated client A			in the home will receive retra	ining	
		aggressive toward client C and			by a certified trainer in appropriate de-escalation an	d	
		ff applied a one (1) arm mandt			physical intervention procedu		
					projecti intervention procede	2.00.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		15G797	B. WING			09/12/2	011
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2					
414/0					AMERICA ROAD		
AWS				LAFON	ITAINE, IN46940		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	T	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
	three (3) min. (minu	ites). No corrective action	1		Some additional measures a	re	
	was documented.	,			being added to client BSPs to	o	
					address problem behavior ea	arlier	
	-BDDS report on 7/	29/11 incident 7/28/11 at 5pm,			in the chain in order to try to		
		ot verbally and physically			prevent escalation to physica	al	
	_	ent C after the dietician "gave			aggression. New		
		riticism" at the dining room			staff-competency testing		
		out of the group home with	1		procedures are being put into		
		then attacked staff, returned to			place for BSP training. How	<i>'</i>	
		tacked client C and bit her on			facility will identify other		
		ctive action was documented.			residents potentially affecte	ed &	
					what measures taken All		
	-BDDS report on 7/	18/11 for an incident which			residents affected, and corre		
	involved police on ?	7/17/11 at 8pm, indicated a			action will address the needs	s of	
		s A, B, and C with 3 staff			all clients in the home.		
	trying to separate th	em. The report indicated			Measures or systemic chan	-	
		client D on the phone. Mandt			facility put in place to ensu		
	restraints were appl	ied to clients A, B, and C by			no recurrence Training of sta		
	the staff until calm.	No corrective action was			members on de-escalation a	nd	
	documented.				appropriate physical		
					management. BSP modificat	ions	
	-BDDS report on 7/	18/11 incident 7/16/11 at 4pm,			to try to prevent behavioral		
	indicated client A be	ecame upset and hit client C.			escalation. New		
	Client A left AWOL	with staff following her. The			competency-based training	initial	
	report indicated clie	ent A had mandt restraints			method put in place for both	Iriiliai	
	applied by the facili	ty staff, calmed, and returned			training as well as on-going competency testing. How		
	to the group home.	No corrective action was			corrective actions will be		
	documented.				monitored to ensure no		
					recurrence House Manager		
	Eight (8) additional	BDDS reports for incidents on			supervises staff, including		
	9/4/11 at 6pm, on 9/	/3/11 at 9pm, on 8/15/11 at			ensuring appropriate training	i	
		8pm, on 8/9/11 at 6pm, on	1		The Behavior Clinician revise		
		/19/11 at 6pm, and on 7/17/11	1		BSP procedures and implem		
	at 9:30am, for clien	t A which involved the mandt			training, including the new		
		eal Aggression and client A's	1		competency-based procedur	es	
		ere documented with no			being put into place. W 149		
		cumented and no follow up to	1		Detail #3 Completing Thorou		
	determine the effect	tiveness of client A's plans.	1		Investigations. Corrective		
			1		action for resident(s) found	to	
	For client B:		1		have been affected All		
					 		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G797 09/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9029 S AMERICA ROAD **AWS** LA FONTAINE, IN46940 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE professional staff members responsible for investigations will -BDDS report on 7/15/11 incident 7/14/11 at be trained on both the Agency 8:30am, indicated client B woke up upset and policy as well as how to conduct wanted to choose her own breakfast. The report thorough investigations. How indicated the unidentified staff redirected client B facility will identify other multiple times. Client B became physically residents potentially affected & aggressive toward staff, banged her head and bit what measures taken All herself. Client B left the area then returned with a residents affected, and corrective bottle of tea which she swung and hit the staff. action will address the needs of The report indicated client B had a Mandt one arm all clients in the home. restraint applied from behind for one (1) minute. Measures or systemic changes Client B dropped to the floor, and began to bang facility put in place to ensure her head and kicked staff, mandt restraint again no recurrence Training will be applied for 3 min. No corrective action was completed, and an Incident documented Oversight Committee will be established. How corrective -BDDS report on 7/11/11 incident on 7/9/11 at actions will be monitored to 10am, indicated client B woke up upset. Client B ensure no recurrence The began to bite herself, swung and hit the staff, and QDDP conducts investigations staff applied Mandt one (1) arm restraint for 2 supervised by the Regional min. Client B made threats to elope, grabbed the Director. The Regional Director phone and called 9-1-1. The report indicated staff supervises professional staff, applied a Mandt one arm restraint for 2 min. including ensuring training Client B hit staff and threw money which other requirements are met. The staff were counting. Staff applied a Mandt one Incident Oversight Committee will arm restraint for 2 min. No corrective action was review all Investigations to documented. determine if appropriate action was taken, including whether -BDDS report on 7/8/11 for an incident with follow-up actions to prevent police involvement on 7/7/11 at 2pm, indicated recurrence were put in place. client B became upset at the store, awol out of the store, and ran into traffic in the parking lot. Client B was hitting staff and staff applied a one arm mandt restraint. Client B was released and hit the staff more. The report indicated an off duty police officer called the dispatcher, and two additional police arrived. Client B got physically aggressive with police, was placed in hand cuffs but was not arrested. No corrective action was documented.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G797		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 09/12/2	LETED	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE AMERICA ROAD ITAINE, IN46940	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	altercations with sta applied on 9/5/11 at 8/6/11 at 7:15pm, or 2:30pm, and on 7/13 action was documer. For client C: -BDDS report on 8/3:30pm, indicated c because client C wa herself and scratchin one (1) arm mandt r corrective action was documented. -BDDS Report 8/22 indicated client C was Behavior) of biting used a one (1) arm r Client C had bite ma areas of the skin. In documented. -BDDS report on 8/indicated client C was client C was indicated client C was client A bit client C began biting herself facility staff applied for one (1) minute. 30 minutes later clie way, then banged he arm mandt restraint corrective action was -BDDS report on 7/4pm, indicated clier.	30/11 incident on 8/29/11 at lient C was redirected by staff is upset. Client C was biting ag her face. Staff applied a estraint for one (1) minute. No is documented and no state of the staff intervened and no staff intervened and no staff intervened and no staff intervened and not not restraint for one (1) minute. Staff intervened and not					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/12/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	2		9029 S	DDRESS, CITY, STATE, ZIP CODE AMERICA ROAD ITAINE, IN46940		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΈ	(X5) COMPLETION DATE
	and interviews were At 1:50pm, client A facility staff hit ano had seen "staff hit" cigarettes." Client A about this on 8/30/1 stated "They gave not talk about it." At was "afraid sometin They gave me cigar don't smoke." Client kick." At 2pm, clientalk about anything go back to the state (Direct Care Staff) on 8/30/11 in the "not duty at the group he (8/29/11) when the 8/30/11 BDDS report or clients A, B, and if the allegation "was notified the agency DCS #1 stated cliental had hit, yelled at cliental cigarettes to smoke house meeting" with discuss" the matter. On 9/9/11 at 1pm, a "Bureau of Develop Policy and Guideling policy and procedure and Mistreatment of the company to ensistip psychological abuse limited to facility staff.	Opm until 2:50pm, observation e completed at the group home. indicated she did not see a ther client. Client A stated she and "tell us to smoke A indicated she had told a staff 1 in the morning. Client A ne cigarettes, but I was told not a 1:55pm, client C stated she nes, staff hurt my feelings. The cettes and told me not to tell, I not C stated staff "don't hit, they not B stated she did not want to "because (she) did not want to "because (she) did not want to hospital." At 2:05pm, DCS #1 stated client A had told her norning" when DCS came on ome about the night before allegation occurred (for the lort). DCS #1 stated she spoke C in the morning to determine as reportable" before DCS #1 in the evening of 8/30/11. Its A, B, and C "all said staff ents," and had given clients. DCS #1 stated "we had a histaff "about a week later to the review was completed of the omental Disability Services nes," dated 10/05. The BDDS are indicated "Abuse, Neglect, for Individualsit is the policy of our that individuals are not all, verbal, sexual, or the by anyone including but not affother individuals, or oolicy indicated "Neglect, the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UFRV11 Facility ID: 012563

If continuation sheet

Page 25 of 56

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G797		(X2) MULTIPLE CO A. BUILDING B. WING	00	ľ	E SURVEY PLETED /2011		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA ROAD LA FONTAINE, IN46940				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	emotional, physical, sources of such supp and such failure resupsychological harm policy indicated the allegations of abuse clients. The facility would take corrective when the facility desystematically would abuse/neglect. The implementation of the prohibit abuse, neglementation of the incidents for pattern after each incident, investigations, and in programs. No retrain of incidents were averaged on 9/12/11 at 11:20 was completed. The not immediately reported BDDS according to the facility did not he implementation procedure for abuse SD indicated no documented on such such such such such such such such	to the individual." The facility facility would investigate a neglect, and mistreatment of policy indicated the facility action during investigations termined corrective action deprotect the clients from facility neglected to ensure their policy and procedures to eet, and mistreatment. In, an interview with the Site completed. The SD indicated tence was available for review ty leadership reviewed s, considered corrective action completed through monitored the clients' ming for immediately reporting ailable for review. In an interview with the SD to indicated the facility did ort allegations of abuse, ment and should have do to the administrator and to state law. The SD indicated the versight of of the agency's policy and a neglect, mistreatment. The sumented corrective measures and none were available for					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G797	B. WIN	G		09/12/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE AMERICA ROAD		
AWS			LA FONTAINE, IN46940				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0153	The facility must emistreatment, neglinjuries of unknown immediately to the officials in accordate established proced. Based on observatinterview, for 3 of (clients A, B, and incidents reports through 9/7/11, thimmediately reports and to BDDS (Budisability Services state law. Findings include: The facility's BD Developmental Experies from 7/1/	nsure that all allegations of lect or abuse, as well as a source, are reported administrator or to other acceptance with State law through dures. Action, record review, and of 3 sample clients at C) and for 7 of 26 reviewed from 7/1/11 the facility failed to out allegations of abuse, reatment and failed to out client to client on to the administrator areau of Developmental tes) in accordance with	W	0153	W 153 Detail #1 Immediate Reporting of Allegations of A Neglect, and Mistreatment. Corrective action for resident(s) found to have b affected Staff member who reported the abuse allegation will receive training on promy reporting of all allegations. Professional staff will receive training on Agency Policy. If facility will identify other residents potentially affecte what measures taken All residents affected, and corre action will address the needs all clients in the home. Measures or systemic char facility put in place to ensu no recurrence In addition to staff member who reported to allegation late, all other staff members in the home will be trained about the requirement	een In late of How ed & ective s of re the	10/12/2011
	indicated the following				immediately report all allegations. Professional stareceive training on Agency p	olicy.	
	*	rt on 8/30/11 incident on			An Incident Oversight Comm	ittee	
	8/29/11 at 4pm ir	ndicated clients A, B, and			will be established. How		
	C made an allega	tion against Direct Care			corrective actions will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UFRV11 Facility ID:

012563 If continuation sheet Page 27 of 56

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION		A. BUI	LDING	00		
		15G797	B. WIN	G		09/12/2	011
NAME OF I	PROVIDER OR SUPPLIEF	- }		1	DDRESS, CITY, STATE, ZIP CODE	-	
AVAC				1	AMERICA ROAD TAINE, IN46940		
AWS				LAFON	TAINE, IN46940		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	_	TAG	· · · · · · · · · · · · · · · · · · ·		DATE
	` ′ ′	#5, and #6 for hitting,			monitored to ensure no		
	1 2	ng the clients cigarettes in		recurrence House Manager supervises staff and ensures			
	the group home.	The 8/30/11 QMRP			proper training. The Regiona		
	(Qualified Menta	al Retardation			Director supervises profession		
	Professional) inv	estigation results			staff and ensures their training	ng.	
	unsubstantiated	the allegations and no			The Incident Oversight		
	action was recon	nmended to be taken.			Committee will review all Inc		
	The 8/30/11 OM	RP investigation			Reports and Investigations to determine if appropriate action		
	-	nts A and B did not			was taken to resolve the		
					immediate incident, whether		
	actually view facility staff #4, #5, and #6 hit another client; however both clients A and B continued to state to the QMRP that				actions adhered to agency p	olicy,	
					and will evaluate if sufficient		
		•			follow-up actions to prevent	14/	
	1	#6 yelled at clients in the			recurrence are put in place. 153 Detail #2 Reporting	W	
	-	continued to give the			Client-to-Client Aggression.		
	_	to encourage the clients			Corrective action for		
	to smoke.				resident(s) found to have b	een	
					affected Staff will receive tra		
	2. A BDDS repo	ort on 8/22/11 incident			on the need to immediately r	•	
	8/20/11 at 7pm,	client A was angry with			client-to-client aggression, so	that	
	client C in kitche	en, and an unidentified			an Incident Report can be completed and an investigati	on	
	staff stepped bet	ween clients A and C.			begun. Professional staff will		
		ated client A attacked the			receive training on Agency P		
		the staff applied a			How facility will identify of		
	1 ^	nold three (3) minute.			residents potentially affecte	ed &	
					what measures taken All		
	3 A BDDS reno	ort on 8/4/11 incident			residents affected, and corre action will address the needs		
	_	n, indicated client A			all clients in the home.	S OI	
	_	C push a staff person.			Measures or systemic char	iges	
		-			facility put in place to ensu	-	
	_	ated client A became			no recurrence All staff mem		
	1	ssive toward client C and			in the home will be trained al		
		staff applied a one (1)			the requirement to immediate	-	
	arm mandt three (3) min. (minutes).				report client-to-client aggress to a supervisor. Professiona		
					staff will receive training on	•	
	4. A BDDS repo	ort on 7/18/11 incident			ctan win receive training on		

012563

		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G797	B. WIN	IG		09/12/20)11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
					AMERICA ROAD		
AWS				LAFON	ITAINE, IN46940		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	гЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1 .	ndicated client A became			Agency policy. An Incident Oversight Committee will be		
	1 ^	nt C. Client A left			established. How corrective	e l	
		f following her. The			actions will be monitored to		
	report indicated of	client A had mandt			ensure no recurrence Hous	е	
	_ ^ ^	by the facility staff,			Manager supervises staff an		
	calmed, and retur	rned to the group home.			ensures proper training. The		
					Regional Director supervises professional staff and ensure		
	5. A BDDS repo	ort on 7/11/11 incident on			their training. The Incident	~	
	7/9/11 at 10am, i	ndicated client B woke			Oversight Committee will rev	riew	
	up upset. Client	B began to bite herself,			all Incident Reports and		
	swung and hit the	e staff, and staff applied			Investigations		
	Mandt one (1) ar	m restraint for 2 min.					
	Client B made th	reats to elope, client B					
		ne and called 9-1-1. The					
		staff applied a Mandt one					
	1 ^	2 min. Client B hit staff					
		which other staff were					
	l	applied a Mandt one arm					
	restraint for 2 mi						
		nutes.					
	6 A RDDS ropo	ort on 8/4/11 incident					
	1	dicated client C was					
	1	t A and client A bit client					
		Then client C began biting					
	_	ort indicated the facility					
		te (1) arm mandt restraint					
	` ′	e. The report indicated					
		ites later client C pushed					
		ray, then banged her head,					
		e (1) arm mandt restraint					
	for one (1) minut	e.					
	_	ort on 7/18/11 incident on					
	7/16/11 at 4pm, i	ndicated client A					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUI	LDING	00		COMPL	
		15G797	B. WIN				09/12/2	U11
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STAT			
					AMERICA ROAD			
AWS				LAFON	TAINE, IN46940			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCEI	E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	E	COMPLETION
TAG		it alient C twice once in	+	TAG	DEFIC			DATE
	"attacked" and hit client C twice, once in back and once in head.							
	back and once in	nead.						
	On 0/7/11 from 1	1:20pm until 2:50pm,						
	observation and	•						
		group home. At 1:50pm,						
	•	d she did not see a facility						
		client (regarding example						
		ited she had seen "staff						
	· ·	to smoke cigarettes."						
		ed she had told a staff						
		0/11 in the morning.						
		They gave me cigarettes,						
		t to talk about it." At						
		stated she was "afraid						
	-							
	-	hurt my feelings. They						
		es and told me not to tell, Client C stated staff						
	<u>-</u>	ick." At 2pm, client B t want to talk about						
		se (she) did not want to						
		ate hospital." At 2:05pm,						
	_	re Staff) #1 stated client A						
	`	3/30/11 in the "morning"						
		on duty at the group						
		night before (8/29/11)						
		ion occurred (for the						
	_	eport). DCS #1 stated she						
	spoke to clients A, B, and C in the							
	morning to determine if the allegation "was reportable" before DCS #1 notified the agency in the evening of 8/30/11.							
		lients A, B, and C "all						
		yelled at clients," and						
		•						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	UFRV11	Facility I	D: 012563	If continuation sh	neet Pa	ge 30 of 56

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/12/2011			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA ROAD LA FONTAINE, IN46940						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
	DCS #1 stated "v	cigarettes to smoke. ve had a house meeting" a week later to discuss"							
	the Site Director The SD indicated documentation th immediately repo neglect, or mistre indicated the fact report to the adm in accordance wi indicated staff sh reported incident	orted allegations of abuse,							
	This federal tag in #IN00095983.	relates to complaint							
W0154	Based on observation interview, for 3 of 3 and C), the facility f	ave evidence that all are thoroughly investigated. n, record review, and sample clients (clients A, B, ailed to thoroughly investigate allegations of abuse, neglect,	W	0154	W 154 Thorough Investigation Corrective action for resident(s) found to have be affected All professional staff members responsible for investigations will be trained both the Agency policy as we how to conduct thorough investigations. How facility	een f on ell as	10/12/2011		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UFRV11 Facility ID:

012563 If continuation sheet Page 31 of 56

l i '		(X2) M	ULTIPLE CO	NSTRUCTION	X3) DATE SURVEY	
		A. BUI	LDING	00	COMPLETED	
		15G797	B. WIN	G		09/12/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
					AMERICA ROAD	
AWS				LA FON	ITAINE, IN46940	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	The facility's BDDS Disability Services) 9/7/11 were reviewe indicated the following at 4pm indicated clie allegation against Disability and #6 for hitting, you cigarettes in the grow (Qualified Mental R investigation results allegations and no at taken. The 8/30/11 documented clients allegations and no at taken. The 8/30/11 documented clients afacility staff #4, #5, however both clients the QMRP that staff clients in the group I and encourage the clients A and B were and encouraging the 2. A BDDS report of 7pm, client A was an and an unidentified sand C. The report in staff person and the hold three (3) minute available for review. 3. A BDDS report of 4:30pm, indicated claes a staff person. The report of the came physically a the unidentified staff.	(Bureau of Developmental reports from 7/1/11 through ed on 9/7/11 at 11:20am and ing: on 8/30/11 incident on 8/29/11 ents A, B, and C made an irect Care Staff (DCS) #4, #5, elling, and giving the clients up home. The 8/30/11 QMRP etardation Professional) unsubstantiated the ection was recommended to be QMRP investigation A and B did not actually view and #6 hit another client; s A and B continued to state to feel, \$4, \$4, \$5, and \$46 yelled at thome and continued to give lients to smoke cigarettes. The trindicate the allegations by a investigated for staff yelling to clients to smoke cigarettes. on 8/22/11 incident 8/20/11 at angry with client C in kitchen, staff stepped between clients A andicated client A attacked the staff applied a physical mandt te. No investigation was on 8/4/11 incident 8/2/11 at the lient A witnessed client C push report indicated client A ggressive toward client C and f applied a one (1) arm mandt tes). No investigation was			identify other residents potentially affected & what measures taken All residents affected, and corrective action address the needs of all clier the home. Measures or systemic changes facility p place to ensure no recurrer Training will be completed, a an Incident Oversight Comm will be established. How corrective actions will be monitored to ensure no recurrence The QDDP cond investigations supervised by Regional Director. The Region Director supervises profession staff, including ensuring train requirements are met. The Incident Oversight Committe review all Investigations to determine if appropriate action was taken, including whether follow-up actions to prevent recurrence were put in place	s on will onts in ut in oce ond other onal onal onal onal on

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G797		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/12/2011		
NAME OF PROVIDER OR SUPPLIER AWS				9029 S	DDRESS, CITY, STATE, ZIP CODE AMERICA ROAD TAINE, IN46940		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	5pm, indicated clier aggressive with clie [client A] positive of table. Client A rand staff following her, group home then att the head. The invedocumented on the 5. A BDDS report of which involved politicated a fight bet 3 staff trying to septimidicated 9-1-1 was phone. Mandt restrand C by the staff undocumented the fact narrative which indicated the fact narrative which indicated. The irrificate of the clients were in 6. A BDDS report of 4pm, indicated client C. Client A left AW. The report indicated applied by the facilit to the group home. For review. 7. A BDDS report of 8:30am, indicated c wanted to choose he indicated the unider multiple times. Client aggressive towards herself. Client B le bottle of tea which staff in the staff	on 7/18/11 for an incident to on 7/18/11 at 8pm, ween clients A, B, and C with arate them. The report called by client D on the aints applied to clients A, B, ntil calm. The investigation ts of the report and a QMRP icated "the staff" were exestigation did not document					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/12/2011		
NAME OF PROVIDER OR SUPPLIER AWS			-	9029 S	.DDRESS, CITY, STATE, ZIP CODE AMERICA ROAD ITAINE, IN46940		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Client B dropped to her head and kicked	m behind for one (1) minute. the floor, and began to bang I staff, mandt restraint again No investigation was available					
	at 10am, indicated of B began to bite hers and staff applied Mimin. Client B made phone and called 9-applied a Mandt one Client B hit staff an staff were counting.	on 7/11/11 incident on 7/9/11 client B woke up upset. Client self, swung and hit the staff, andt one (1) arm restraint for 2 ce threats to elope, grabbed the 1-1. The report indicated staff to arm restraint for 2 min. d threw money which other Staff applied a Mandt one min. No investigation was					
	police involvement client B became ups store, and client B r Client B was hitting arm mandt restraint the staff more. The police officer called additional police arr aggressive with poli	on 7/8/11 for an incident with on 7/7/11 at 2pm, indicated set at the store, left awol out of an into traffic in parking lot. It is staff and staff applied a one at Client B was released and hit report indicated an off duty at the dispatcher, and two crived. Client B got physically ice, was placed in hand cuffs be investigation was					
	4pm, indicated clier and client A bit clier C began biting herse facility staff applied for one (1) minute. 30 minutes later clie way, then banged here.	c on 8/4/11 incident 8/2/11 at at C was attacked by client A at C on the head. Then client elf. The report indicated the I a one (1) arm mandt restraint The report indicated less than ent C pushed staff out of her er head, staff applied a one (1) for one (1) minute. No					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
15G797		A. BUI	LDING	00	09/12/2			
		150/9/	B. WIN	_		09/12/20	011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE			
A) A (O	4440				AMERICA ROAD			
AWS				LAFON	ITAINE, IN46940			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	investigation was av	railable for review.						
	11 A DDDC man and	7/10/11 in aid and an						
	_	on 7/18/11 incident on cated client A "attacked" and						
		nce in back and once in head.						
		s available for review.						
	140 mvestigation wa	s available for review.						
	On 9/7/11 from 1:20	pm until 2:50pm, observation						
		completed at the group home.						
	At 1:50pm, client A	indicated she did not see a						
	facility staff hit anot	her client (regarding example						
		she had seen "staff hit" and						
	_	garettes." Client A indicated						
		about this on 8/30/11 in the						
	_	tated "They gave me						
	_	told not to talk about it." At						
	-	ted she was "afraid sometimes,						
		s. They gave me cigarettes						
		ell, I don't smoke." Client C						
		t, they kick." At 2pm, client B						
		ant to talk about anything						
	, ,	ot want to go back to the state n, DCS (Direct Care Staff) #1						
		old her on 8/30/11 in the						
		CS came on duty at the group						
	_	at before (8/29/11) when the						
	_	(for the 8/30/11 BDDS report).						
	-	poke to clients A, B, and C in						
	· ·	mine if the allegation "was						
	_	OCS #1 notified the agency in						
		11. DCS #1 stated clients A,						
	B, and C "all said st	aff had hit, yelled at clients,"						
	-	s cigarettes to smoke. DCS #1						
		ise meeting" with staff "about						
	a week later to discu	iss" the matter.						
	00/0/11 + 2							
		review of the 9/7/11 inservice						
	-	RP and the House Manager						
	_	the QMRP. The QMRP of received training on how to						
	mulcated sile had no	a received training on now to						
	!							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G797		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/12/2011			
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA ROAD LA FONTAINE, IN46940					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		PI	ID REFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG	complete a thorough The QMRP indicate the incident which we on 9/9/11 at 3:35pm Director (SD) was certificated the clients A, B, and aggressive and required holds to prevent injuggressive behavior documented evidence indicate that the faci incidents for pattern indicate what had occincident. On 9/12/11 at 11:20 was completed. The	an, an interview with the Site completed. The SD indicated and C had been physically ired one arm mandt physically ired one arm mandt physically ires during their physically ires during their physically ires available for review to lity leadership reviewed is and the investigations did not becurred before or after each arm, an interview with the SD indicated the facility's not thorough for incidents of cal aggression.		TAG	DEFICIENCY)		DATE	
W0157	Based on observation interview, for 3 of 3 and C), the facility from client to client physimedication errors af Findings include:	tion is verified, appropriate nust be taken. n, record review, and sample clients (clients A, B, failed to take sufficient documented incidents of cal aggression and multiple ter patterns had developed. DS (Bureau of Developmental	W01	157	W 157 Implementation of Effective Corrective Action. Corrective action for resident(s) found to have be affected Incident Oversight Committee will be establishe ensure implementation of effective corrective action for incident reports and investigations. How facility identify other residents	d to	10/12/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UFRV11

Facility ID:

012563 If c

If continuation sheet Page 36 of 56

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP - 09/12/2	LETED
NAME OF F	PROVIDER OR SUPPLIER		STREET 2 9029 S	ADDRESS, CITY, STATE, ZIP CO AMERICA ROAD NTAINE, IN46940	ODE	
	SUMMARY S (EACH DEFICIEN REGULATORY OR Disability Services) 9/7/11 were reviewed indicated the follow A BDDS report on Separated the follow A BDDS report on Separate since allegation against Description and #6 for hitting, yeigarettes in the group (Qualified Mental Resident investigation results allegations and no attaken. The 8/30/11 documented clients facility staff #4, #5, however both clients facility staff #4, #5, however both clients in the group the clients cigarettes smoke. No correction A BDDS report on Separate since and an unidentified and C. The report in staff person and the hold three (3) minut documented.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) reports from 7/1/11 through ed on 9/7/11 at 11:20am and ing: 3/30/11 incident on 8/29/11 at ts A, B, and C made an irect Care Staff (DCS) #4, #5, elling, and giving the clients up home. The 8/30/11 QMRP etardation Professional) unsubstantiated the ction was recommended to be QMRP investigation A and B did not actually view and #6 hit another client; s A and B continued to state to f#4, #5, and #6 yelled at home and continued to give to encourage the clients to we action was documented. 8/22/11 incident 8/20/11 at angry with client C in kitchen, staff stepped between clients A andicated client A attacked the staff applied a physical mandt e. No corrective action was	STREET 2 9029 S	AMERICA ROAD	& what residents ve action will all clients in s or acility put in ecurrence cident and on of trends tment with on plan to corrective tored to ce The ommittee is oliance ionally and tinct from the ll ensure the	(X5) COMPLETION DATE
	4:30pm, indicated c a staff person. The became physically a the unidentified staff	8/4/11 incident 8/2/11 at lient A witnessed client C push report indicated client A aggressive toward client C and f applied a one (1) arm mandt ttes). No corrective action				
	5pm, indicated clier	7/29/11 incident 7/28/11 at at at A got verbally and physically at C after the dietician "gave				

012563

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G797	B. WING		09/12/2011
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	PROVIDER OR SUPPLIER		I	AMERICA ROAD	
AWS				ITAINE, IN46940	
AVVS			LAFON	TAINE, IN40940	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		riticism" at the dining room			
		out of the group home with			
		then attacked staff, returned to			
		acked client C and bit her on			
	the head. No correct	ctive action was documented.			
	A DDDC	7/10/11 6			
		7/18/11 for an incident which 7/17/11 at 8pm, indicated a			
		s A, B, and C with 3 staff			
	_	em. The report indicated			
		client D on the phone. Mandt			
	-	ied to clients A, B, and C by			
		No corrective action was			
	documented.	The Confessive Menors was			
	ao camenoa.				
	A BDDS report on 7	7/18/11 incident 7/16/11 at			
		at A became upset and hit client			
	C. Client A left AW	OL with staff following her.			
	The report indicated	client A had mandt restraints			
		ty staff, calmed, and returned			
	to the group home.	No corrective action was			
	documented.				
	- '	8) additional BDDS reports for			
		at 6pm, on 9/3/11 at 9pm, on			
	*	8/10/11 at 8pm, on 8/9/11 at			
	* '	om, on 7/19/11 at 6pm, and on			
		for client A which involved the			
		Physical Aggression and client were documented with no			
	corrective action do				
	corrective action do	Cumcilieu.			
	A BDDS report on 3	7/15/11 incident 7/14/11 at			
		lient B woke up upset and			
		er own breakfast. The report			
		atified staff redirected client B			
		ent B became physically			
	*	taff, banged her head and bit			
		ft the area then returned with a			
		she swung and hit the staff.			
		-			

			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G797	A. BUI	LDING	00	09/12/2	
		136797	B. WIN			09/12/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
AWS					AMERICA ROAD ITAINE, IN46940		
					TAINE, INTOSTO		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		client B had a Mandt one arm	+	ing	<u> </u>		DATE
		m behind for one (1) minute.					
	* *	the floor, and began to bang					
		staff, mandt restraint again					
		No corrective action was					
	documented.						
	A BDDS report on	7/11/11 incident on 7/9/11 at					
	_	ent B woke up upset. Client B					
	_	f, swung and hit the staff, and					
		one (1) arm restraint for 2					
		threats to elope, grabbed the 1-1. The report indicated staff					
		e arm restraint for 2 min.					
	* *	d threw money which other					
	_	Staff applied a Mandt one					
		nin. No corrective action was					
	documented.						
	A BDDS report on 7	7/8/11 for an incident with					
	_	on 7/7/11 at 2pm, indicated					
		et at the store, left awol out of					
		to traffic in parking lot. Client					
	_	nd staff applied a one arm ent B was released and hit the					
		ort indicated an off duty police					
	_	spatcher, and two additional					
		nt B got physically aggressive					
		ced in hand cuffs but was not					
	arrested. No correc	etive action was documented.					
	Client B had (6) six	additional physical					
		ff and mandt restraints were					
		7am, on 8/12/11 at 4pm, on					
	_	n 8/5/11 at 6pm, on 7/25/11 at					
		3/11 at 8:30am. No corrective					
	action was documen	nted.					
	A RDDS report on S	8/30/11 incident on 8/29/11 at					
	_	lient C was redirected by staff					

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	00	COMPI	ETED
		15G797	B. WIN	IG		09/12/2	U11
NAME OF F	PROVIDER OR SUPPLIER			9029 S	ADDRESS, CITY, STATE, ZIP CODE AMERICA ROAD ITAINE, IN46940		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	herself and scratching one (1) arm mandt r	s upset. Client C was biting ng her face. Staff applied a estraint for one (1) minute. No s documented and no					
	indicated client C w Behavior) of biting used a one (1) arm r Client C had bite ma	2/11 incident 8/21/11 at 6pm, as SIB (Self injurious herself. Staff intervened and nandt restraint for one (1) min. arks were on her arm/wrist to corrective action was					
	indicated client C w client A bit client C began biting herself facility staff applied for one (1) minute. 30 minutes later clie way, then banged he	as attacked by client A and on the head. Then client C The report indicated the a one (1) arm mandt restraint. The report indicated less than ent C pushed staff out of her er head, staff applied a one (1) for one (1) minute. No s documented.					
	4pm, indicated clien	7/18/11 incident on 7/16/11 at at A "attacked" and hit client C and once in head. No s documented.					
	Disability Services)	DS (Bureau of Developmental reports from 7/1/11 through d on 9/7/11 at 11:20am and ing for documented					
	incident 7/31/11 at 4 complained of "SOF	B/1/11 medication error lpm, indicated client B g (shortness of breath) dx hronic Obstructive Pulmonary					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UFRV11 Facility ID:

012563

If continuation sheet

Page 40 of 56

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	15G797	A. BUI	LDING	00	09/12/2	
		100707	B. WIN			03/12/2	011
NAME OF I	PROVIDER OR SUPPLIER	t		1	ADDRESS, CITY, STATE, ZIP CODE		
AWS				1	AMERICA ROAD ITAINE, IN46940		
				LAFOR	TAINE, IN46940		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ort indicated client B had a					
		r Advair 1 time per day. Client					
		ded another puff. The report the additional medication					
	-	e client orders and client B					
	_	e report indicated staff did not					
		ysician orders. The report					
		r was not an as needed					
		port indicated the nurse came					
		and client B was sent out to her					
		ice visit. No corrective action					
	was documented.						
	A DDDG	7/01/11 6					
	*	7/21/11 for a medication error 8am, indicated client B's					
		r Hypertension) was not given					
	· ·	cause staff neglected to read					
	_	Administration Record) and					
	·	etraining." No documented					
		ng was available for review.					
	No corrective action	n was documented.					
	_	7/18/11 for a medication error					
		at 12pm, indicated client B on 7/7/11. A new medication					
		me daily was started and the					
		ued the Lasix medication. The					
		m 7/7/11 through 7/17/11 client					
	-	x med and no Losartan					
	medication. No co	rrective action was					
	documented.						
		n BDDS report for client C's					
		eident documented on 8/1/11,					
		d. The report indicated client C					
		nedication because pharmacy					
		n to refill and was waiting for aformation in regards to the					
		which was being ordered for					
		ble for review. No corrective					
	Table Community	10 001100110					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ND IC	00	COMPL	ETED
		15G797	A. BUILI			09/12/2	011
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
AVAC					AMERICA ROAD		
AWS				LAFON	ITAINE, IN46940		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	action was documen	nted.					
		n, an interview with the Site					
		completed. The SD indicated					
		had been physically aggressive					
	1 -	m mandt physical holds to					
		ing their physical aggressive indicated no documented					
		able for review to indicate that					
		ip reviewed incidents for					
		red corrective action after each					
	1 -	ndicated there was no action					
		no monitoring of the clients'					
	l '	etraining for immediately					
		ats was available for review.					
	On 9/12/11 at 11:20	Dam, an interview with the SD					
	was completed. The	e SD indicated no documented					
	corrective measures	s were implemented and none					
	were available for r	eview.					
		as reviewed on 9/8/11 at 2pm					
		m. Client A's 7/29/11 Behavior					
		indicated reviews on 4/30/11					
		ints to be used for physically					
		rs which are an immediate					
		ety, and welfare for client A and 16/11 for reinforcers to be					
		pliance; on 7/25/11 for					
		iction of activities for property					
		A's BSP did not indicate					
		s for physical aggression and					
	AWOL behaviors.						
	Client B's record wa	as reviewed on 9/8/11 at					
	2:15pm and on 9/9/	11 at 8:30am. Client B's					
	4/8/11 BSP indicate	ed the last review of her BSP					
		ent B's BSP indicated she had					
		of physical aggression and did					
	not indicate reviews	s or revisions for physical					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G797	A. BUII		00	09/12/2	
		100101	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/12/2	
NAME OF P	ROVIDER OR SUPPLIER				AMERICA ROAD		
AWS					TAINE, IN46940		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`			I	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	
IAG			+	IAG	DEFICIENCI)		DATE
PREFIX TAG	aggression behavior. Client C's record wa Client C's 4/8/11 BS behaviors of physica indicate reviews or raggression behavior. This federal tag relation #IN00095983. 1.1-3-2(a) Staff must be able and techniques neinterventions to mabehavior of clients. Based on record revisample clients (client the group home, the demonstrate knowle to manage client A, behaviors. Findings include: The facility's BDDS Disability Services) 9/7/11 were reviewed indicated the follow. For client A: -BDDS report on 8/3/4 pm indicated client.	as reviewed on 9/8/11 at 3pm. Prindicated she had targeted all aggression and did not revisions for physical sector of the secto	W	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	een the by a e	COMPLETION DATE 10/12/2011
		irect Care Staff (DCS) #4, #5,					
	0.1	elling, and giving the clients			Measures or systemic chan facility put in place to ensur	-	
		up home. The 8/30/11 QMRP			no recurrence Training of sta		
	(Qualified Mental R	etardation Professional)			members on de-escalation a		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UFRV11 Facility ID: 012563

If continuation sheet

Page 43 of 56

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G797	B. WING			09/12/2	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t .			AMERICA ROAD		
AWS					ITAINE, IN46940		
AVVO				LATON	TAINE, IN40940		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
	~	s unsubstantiated the			appropriate physical		
	-	ction was recommended to be			management. New		
		QMRP investigation			competency-based training	::4:1	
		A and B did not actually view			method put in place for both	ınıtıaı	
	-	and #6 hit another client;			training as well as on-going competency testing for beha	vior	
		s A and B continued to state to			interventions in BSPs. How		
		f #4, #5, and #6 yelled at home and continued to give			corrective actions will be		
	~ .	s to encourage the clients to			monitored to ensure no		
	_	raining on staff to client			recurrence House Manager		
	interaction was doci	•			supervises staff, including		
	micraevion was acce				ensuring appropriate training		
	-BDDS report on 8/	22/11 incident 8/20/11 at 7pm,			The Behavior Clinician		
		with client C in kitchen, and an			implements training on BSPs	5 ,	
		epped between clients A and C.			including the new		
	The report indicated	I client A attacked the staff			competency-based procedur	es	
	person and the staff	applied a physical mandt hold			being put into place.		
	three (3) minute. N	o documented staff retraining					
	on techniques to ma	nage client behavior was					
	available for review	.					
	_	4/11 incident 8/2/11 at					
		lient A witnessed client C push					
	*	report indicated client A					
		aggressive toward client C and					
		f applied a one (1) arm mandt					
		ites). No documented staff					
	was available for re	ques to manage client behavior					
	was available fol le	vicw.					
	-BDDS report on 7/	29/11 incident 7/28/11 at 5pm,					
	_	ot verbally and physically					
		nt C after the dietician "gave					
		riticism" at the dining room					
		out of the group home with					
		then attacked staff, returned to					
		tacked client C and bit her on					
		nented staff retraining on					
	techniques to manag	ge client behavior was					
	available for review						

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797			(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/12/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	2		9029 S	DDRESS, CITY, STATE, ZIP CODE AMERICA ROAD ITAINE, IN46940		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
	involved police on fight between client trying to separate th 9-1-1 was called by restraints applied to until calm. No corn No documented statemanage client behaves a separate of the separat	BDDS reports for incidents on /3/11 at 9pm, on 8/15/11 at 8pm, on 8/9/11 at 6pm, on /19/11 at 6pm, and on 7/17/11 t A which involved the mandt ral Aggression and client A's lo documented staff retraining image client behavior was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UFRV11 Facility ID: 012563

If continuation sheet

Page 45 of 56

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

l			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAIN	OF CORRECTION	IDENTIFICATION NUMBER: 15G797	- 1	LDING	00	09/12/2	
		100707	B. WIN		A PARAGO CITY CTATE ZIA CORE	03/12/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE AMERICA ROAD		
AWS					ITAINE, IN46940		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		client B had a Mandt one arm behind for one (1) minute.					
		the floor, and began to bang					
		staff, mandt restraint again					
		No documented staff retraining					
		nage client behavior was					
	available for review						
	-BDDS report on 7/	11/11 incident on 7/9/11 at					
		nt B woke up upset. Client B					
	-	, swung and hit the staff, and					
		one (1) arm restraint for 2					
		threats to elope, grabbed the l-1. The report indicated staff					
	*	e arm restraint for 2 min.					
		threw money which other					
	staff were counting.	Staff applied a Mandt one					
		nin. No documented staff					
	-	ques to manage client behavior					
	was available for rev	/1ew.					
	-BDDS report on 7/8	8/11 for an incident with					
		on 7/7/11 at 2pm, indicated					
		et at the store, left awol out of					
		to traffic in parking lot. Client					
	_	nd staff applied a one arm ent B was released and hit the					
		ort indicated an off duty police					
	-	patcher, and two additional					
		nt B got physically aggressive					
		ced in hand cuffs but was not					
		ented staff retraining on					
	techniques to manag available for review	ge client behavior was					
	avanable for fevicw.						
	-Client B had (6) six	additional physical					
		ff and mandt restraints were					
		7am, on 8/12/11 at 4pm, on					
	8/6/11 at 7:15pm, or 2:30pm, and on 7/13	1 8/5/11 at 6pm, on 7/25/11 at					
	2.50pm, and on 7/13	11 at 6.30am. 140					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UFRV11 Facility ID:

012563

If continuation sheet

Page 46 of 56

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	li i	E SURVEY PLETED 2011
NAME OF P	PROVIDER OR SUPPLIER		B. WINC	STREET A 9029 S	DDRESS, CITY, STATE, ZIP CODE AMERICA ROAD TAINE, IN46940		
	SUMMARY S (EACH DEFICIENT REGULATORY OR documented staff return manage client behave the staff and scratching one (1) arm mandt redocumented staff return manage client behave the staff and scratching one (1) arm mandt redocumented staff return manage client behave the staff and scratching one (1) arm mandt redocumented staff return manage client behave the staff and scratching used a one (1) arm reclient C had bite material of the skin. Not the staff of the skin. Not the staff and scratching the staff applied for one (1) minute. BDDS report on 8/4 indicated client C we client A bit client C began biting herself facility staff applied for one (1) minute. 30 minutes later clie way, then banged he arm mandt restraint documented staff return manage client behave the staff applied for one (1) minute.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Training on techniques to vior was available for review. 30/11 incident on 8/29/11 at lient C was redirected by staff s upset. Client C was biting ag her face. Staff applied a estraint for one (1) minute. No training on techniques to vior was available for review. //11 incident 8/21/11 at 6pm, as SIB (Self injurious herself. Staff intervened and mandt restraint for one (1) min. arks were on her arm/wrist o documented staff retraining mage client behavior was		STREET A 9029 S	AMERICA ROAD	TION D BE	(X5) COMPLETION DATE
	4pm, indicated clien twice: once in back documented staff re	18/11 incident on 7/16/11 at at A "attacked" and hit client C and once in head. No training on techniques to vior was available for review.					

Facility ID:

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE 99/12/2011	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A DIVIDING 00 COMPLETED			
NAMIS OF PROVIDER OR SUPPLIER AWS OX JO SUMMARY STATEMENT OF DEFICIENCIES PREFEX (EACH DEFICIENCY MIST BE PERCEDED BY PLLL AGE REGULATORY OR SET DEFINITION INFORMATION) On 9/9/11 at 3/35pm, an interview with the Site Director (SD) was completed. The SD indicated no documented evidence was available for review to indicate the finelity leadership considered or provided retraining of the facility staff did not manage client A, B, and C's physically aggressive behaviors because client aggression continued to occur. The SD stated the agency "will certainly be reviewing" the facility staff six need to be retrained to ensure each clients' Phavior Management Plan and the "least restrictive or verbal redirection to most restrictive or physical holds' were used. This federal tag relates to complaint #!N00095983. 1.1-3-3(a) W0318 Based on observation, record review, and interview, the Condition of Participation. Health Care Services, was not met as the facility failed to provide adequate health care monitoring and oversight of medication administration for 2 of 3 sampled clients (clients B and C), be please refer to W331. The facility failed to follow physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), to ensure clients B and C), who by physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), who by physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), who by physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), to ensure clients B and C), who by physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), who be a client place to ensure the physican's orders for medication administration for 2 of 3 sampled clients (clients B and C), who be a client place to ensure the physican's orders for medication administration for 2 of 3 sampled clients (clients Glean B). The facility failed to follow physican's orders for medicatio	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G797		00		
AWS SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX TAG			100101		ET ADDRESS CITY STATE ZID CODE	00/12/2011	
AWS D SUMMARY SIXTEMENT OF DEPICIENCY STATE PREFIX TAG REGULATORY ON LSC IDENTIFYING INFORMATION) TAG Completed The SD indicated no documented evidence was available for review to indicate the facility leadership considered or provided retraining of the facility staff did not manage client A, B, and C's physically aggressive behaviors because client aggression continued to occur. The SD stated the agency "will certainly be reviewing" the facility staff and the "least restrictive or verbal redirection to most restrictive or physical holds" were used. This federal tag relates to complaint #IN00095983. 1.1-3-3(a) W0318 The facility must ensure that specific health care services requirements are met. W0318 W318 Oversight of Medication Administration Corrective action for resident(s) found to have been affected Agency Nurse will conduct a med pass observation for each staff member across shifts. A new system will be trained across staff that improves accuracy. How facility will identify other residents potentially affected & what measures taken All residents affected, and corrective action will address the needs of all clients to their medical needs. Please refer to W338. The facility failed to follow physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), to ensure clients B and C received nursing services oversight according to their medical needs. Please refer to W368. The facility failed to follow physician's orders for medication administration for 2 of 3 sample clients (clients B and C), who have been affected and corrective action will address the needs of all clients in the home. Measures or systemic changes facility put in place to ensure no recurrence Medication Pass.	NAME OF P	ROVIDER OR SUPPLIER					
PREFIX TAG RICCHAINCY MUST BE PERCEDED BY FULL PREFIX CROSS PREFIXENCE TO THE APPROPRIATE COMPLETION DATE On 9/9/11 at 3:35pm, an interview with the Stie Director (SD) was completed. The SD indicated no documented evidence was available for review to indicate the facility staff did not manage client A, B, and C's physically aggressive behaviors because client aggression continued to occur. The SD stated the agency "will certainly be reviewing" the facility staff did not manage client A, B, and C's physically aggressive behaviors because clients Behavior Management Plan and the "least restrictive or physical holds" were used. This federal tag relates to complaint ##IN00095983. 1.1-3-3(a) The facility must ensure that specific health care services requirements are met. Based on observation, record review, and interview, the Condition of Participation, Health Care Services, was not met as the facility failed to provide adequate health care monitoring and oversight of medication administration for 2 of 3 sample clients (clients B and C). Findings include: Please refer to W331. The facility failed for 2 of 3 sampled clients (clients B and C), to ensure clients B and C received nursing services oversight according to their medical needs. Please refer to W368. The facility failed to follow physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), to ensure clients B and C received nursing services oversight according to their medical needs. Please refer to W368. The facility failed to follow physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), who	AWS						
On 99/11 at 3:35pm, an interview with the Site Director (SD) was completed. The SD indicated no documented evidence was available for review to indicate the facility staff and not manage client A, B, and C's physically aggressive behaviors because client aggression continued to occur. The SD stated the agency "will certainly be reviewing" the facility staff's need to be retrained to ensure each clients' Behavior Management Plan and the "least restrictive or verbal redirection to most restrictive or orphiscal holds" were used. This federal tag relates to complaint #IN00095983. 1.1-3-3(a) W0318 The facility must ensure that specific health care services requirements are met. Based on observation, record review, and interview, the Condition of Participation, Health Care Services, was not met as the facility failed to provide adequate health care monitoring and oversight of medication administration for 2 of 3 sample clients (clients B and C). Findings include: Findings include: Flease refer to W331. The facility failed for 2 of 3 sampled clients (clients B and C) to ensure clients B and C received nursing services oversight according to their medical needs. Please refer to W368. The facility failed to follow physician's orders for medication administration for 2 of 3 sample clients (clients B and C), to ensure clients B and C received nursing services oversight according to their medical needs. Please refer to W368. The facility failed to follow physician's orders for medication administration for 2 of 3 sample clients (clients B and C), to ensure clients B and C), to how						· · ·	
On 99/911 at 31-35pm, an interview with the Site Director (SD) was completed. The SD indicated no documented evidence was available for review to indicate the facility staff din of manage client A, B, and C's physically aggressive behaviors because client aggression continued to occur. The SD stated the agency "will certainly be reviewing" the facility staff din ofto manage client A, B, and C's physically aggressive behaviors because client aggression continued to occur. The SD stated the agency "will certainly be reviewing" the facility staff din ofto manage ment and the fleast restrictive or rephysical holds" were used. This federal tag relates to complaint #IN00095983. 1.1-3-3(a) The facility must ensure that specific health care services requirements are met. Based on observation, record review, and interview, the Condition of Participation, Health Care Services, was not met as the facility failed to provide adequate health care monitoring and oversight of medication administration for 2 of 3 sample clients (clients B and C). Findings include: Please refer to W331. The facility failed for 2 of 3 sampled clients (clients B and C), to ensure clients B and C received nursing services oversight according to their medical needs. Please refer to W368. The facility failed to follow physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), to ensure clients according to their medical needs. Please refer to W368. The facility failed to follow physician's orders for medication administration for 2 of 3 sampled clients (clients B and C), who		`			CROSS-REFERENCED TO THE APPROPRIA	TE	
Director (SD) was completed. The SD indicated no documented evidence was available for review to indicate the facility leadership considered or provided retraining of the facility staff. The SD indicated the facility staff and to manage client A, B, and C's physically aggressive behaviors because client aggression continued to occur. The SD stated the agency "will certainly be reviewing" the facility staff's need to be retrained to ensure each clients Behavior Management Plan and the "least restrictive or verbal redirection to most restrictive or physical holds" were used. This federal tag relates to complaint #IN00095983. 1.1-3-3(a) W0318 The facility must ensure that specific health care services requirements are met. W0318 Based on observation, record review, and interview, the Condition of Participation, Health Care Services, was not met as the facility failed to provide adequate health care monitoring and oversight of medication administration for 2 of 3 sample clients (clients B and C). Findings include: Findings include: Please refer to W331. The facility failed for 2 of 3 sampled clients (clients B and C), to ensure clients B and C received nursing services oversight according to their medical needs. Please refer to W368. The facility failed to follow physician's orders for medication administration for 2 of 3 sample clients (clients B and C), to ensure clients B and C, to ensure clients B and C received nursing services oversight according to their medical needs. Please refer to W368. The facility failed to follow physician's orders for medication administration for 2 of 3 sample clients (clients B and C), to how facility put in place to ensure no recurrence Medication Pass	TAG		<u> </u>	TAG	DEFICIENCY)	DATE	
the Nurse. Nurse also is	W0318	Director (SD) was ceno documented evide to indicate the facility provided retraining indicated the facility B, and C's physically client aggression constated the agency "we facility staff's need to clients' Behavior Marestrictive or verbal or physical holds" we This federal tag relation with the facility must example clients adequate he oversight of medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C received nu according to their medical sample clients (clients and C	ompleted. The SD indicated lence was available for review ty leadership considered or of the facility staff. The SD v staff did not manage client A, y aggressive behaviors because intinued to occur. The SD vill certainly be reviewing" the obe retrained to ensure each anagement Plan and the "least redirection to most restrictive vere used. Ites to complaint Insure that specific health hirements are met. In, record review, and ition of Participation, Health not met as the facility failed to alth care monitoring and tion administration for 2 of 3 ants B and C). In The facility failed for 2 of 3 ants B and C), to ensure clients arising services oversight edical needs. In the facility failed to follow or medication administration ents (clients B and C), who	W0318	Administration Corrective action for resident(s) found have been affected Agency Nurse will conduct a med parabete observation for each staff member across shifts. A new system will be trained across that improves accuracy. He facility will identify other residents potentially affected what measures taken All residents affected, and correspond all clients in the home. Measures or systemic characteristics for the potential of t	ss W s staff bw ed & ective s of nges re ass	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UFRV11 Facility ID: 012563

If continuation sheet

Page 48 of 56

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G797		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SI COMPLE 09/12/20	TED			
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA ROAD LA FONTAINE, IN46940					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
	error from 7/1/11 th 1.1-3-6(a)			implementing a new "dot" medication administration that gives staff a way to che their work and enhance acknowledge with each pill popped repropersion by a dot on the MAR, so the count dots and pills to ensist they match up; We will consist match up; We will consist member passing medicated by another staff person; For any Medication Errors in the future, there corrective action, which we incorporate training of staff made error and staff mem who acted as buddy checknown when appropriate. Repeaterors may include disciplication up to and including termination. How correct actions will be monitored ensure no recurrence The Nurse oversees Health Cambon Monitoring of staff and professional staff, including nurse, and will continue to with them regularly. These meetings will now include agenda items, including medication administration updates. All medication eresult in Incident Reports. New Incident Oversight Committee will meet week ensure that adequate correction is taken if a medicaterror occurs. Staff disciplication is conducted by the	neck ccuracy esented ney ure ntinue ere the dication f n will be II f who ber ker ted nary tive I to e are vides anal g the meet e new rrors The Ily to ective tion nary			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UFRV11

Facility ID:

012563

If continuation sheet

Page 49 of 56

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		15G797	B. WIN			09/12/2	011
NAME OF F	PROVIDER OR SUPPLIER			9029 S	DDRESS, CITY, STATE, ZIP CODE AMERICA ROAD TAINE, IN46940		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	-	DATE
W0331		rovide clients with nursing ance with their needs.	W	0331	Manager. W 331 Providing Nursing		10/12/2011
	failed for 2 of 3 sam to ensure clients B a oversight according Findings include:	iew and interview, the facility pled clients (clients B and C), and C received nursing services to their medical needs. (Bureau of Developmental	W	0331	W 331 Providing Nursing Oversight according to Medic Needs Corrective action for resident(s) found to have be affected Agency's Director of Health Services will provide training to nurse on Agency's Medication Error Policy, how work with staff to maximize	or een f	10/12/2011
	Disability Services) 9/7/11 were reviewe indicated the follow medication errors:	reports from 7/1/11 through d on 9/7/11 at 11:20am and ing for documented			effective medication administration, and how to follow-up on any errors with effective follow-up. How fac will identify other residents potentially affected & what	-	
	incident 7/31/11 at 4 complained of "SOE COPD (diagnosis CI Disease)." The repophysician's order for B told staff she need indicated staff gave without checking the exhibited SOB. The follow client B's phy indicated the Advair medication. The repout to her physician' corrective action was	on 8/1/11 medication error pm, indicated client B B (shortness of breath) dx pronic Obstructive Pulmonary rt indicated client B had a P Advair 1 time per day. Client red another puff. The report the additional medication re client orders and client B report indicated staff did not resician orders. The report was not an as needed rort indicated client B was sent s office by the nurse. No s documented by the nurse.			measures taken All residents affected, and corrective action address the needs of all clier the home. Measures or systemic changes facility p place to ensure no recurrent Training provided by Agency Director of Health Services. How corrective actions will monitored to ensure no recurrence The Director of Health Services works with the Compliance office to ensure appropriate policies are in pla and trains agency nurses. The Regional Director supervises	n will nts in ut in nce 's be ne ace he	
	error incident 7/20/1 Losartan HTCZ (for 7/20/11 morning bed MAR (Medication A "staff will receive re	nn 7/21/11 for a medication 1 at 8am, indicated client B's Hypertension) was not given cause staff neglected to read administration Record) and training." No documented g was available for review.			nurse. The new Incident Oversight Committee will rev all incidents, including medic errors, and will ensure appropriate corrective action taken by professional staff, including the nurse.	iew ation	

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PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE (COMPL 09/12/2	ETED
NAME OF I	PROVIDER OR SUPPLIEF	e.		9029 S	DDRESS, CITY, STATE, ZIP CODE AMERICA ROAD TAINE, IN46940		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	error incident on 7/B went to the docto Losartan HTCZ 1 ti physician disconting report indicated from B received the Lasis medication. No condocumented by the 4. There was no wrow C's medication error 8/1/11, no time docto indicated client C medication because authorization. No intrope of medication of client C was available action was documented retrain. The House Manage Meeting agenda and held monthly to have problems in the group of 1/2/11 at 11:20 Director (SD) was of the facility had retraine medications not bein physician orders and up to the incidents. had had three (3) di 5/2011. The SD incomposition of the incidents.	ritten BDDS report for client report incident documented on the statement hissed three (3) doses of pharmacy needed ll and was waiting for afformation in regards to the which was being ordered for the for review. No corrective need by the nurse. 30am until 1:10pm, facility training were requested. No sing was available for review. It provided an undated "House and indicated the meeting was we a discussion with staff about					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO		COMPL	COMPLETED	
		15G797	B. WING 09/12/2011			011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
					AMERICA ROAD		
AWS				LAFON	ITAINE, IN46940		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	the incidents.		1				
	1.1-3-6(a)						
W0368	The system for dru	ug administration must					
	assure that all drug	gs are administered in					
	compliance with th	ne physician's orders.					
			W	0368	W 368 Following Through on		10/12/2011
	Pagad on record ray	iew and interview for 2 of 3			Physician Orders for Medicat	tion	
		nts B and C) who had			Administration Corrective		
		stered by facility staff in error			action for resident(s) found	to	
		9/7/11, the facility failed to			have been affected Agency		
		rders for medication			Nurse will conduct a med pas	SS	
	administration.	ruers for interieuron			observation for each staff		
					member across shifts. Agen	-	
	Findings include:				Director of Health Services w	/111	
	8				provide training to nurse on Agency's Medication Error Po	olicy	
	The facility's BDDS	(Bureau of Developmental			how to work with staff to	Olicy,	
	-	reports from 7/1/11 through			maximize effective medicatio	n	
	9/7/11 were reviewe	ed on 9/7/11 at 11:20am and			administration, and how to		
	indicated the follow	ing for documented			follow-up on any errors		
	medication errors:				effectively. How facility will		
					identify other residents		
	1. A BDDS report of	on 8/1/11 medication error			potentially affected & what		
		4pm, indicated client B			measures taken All residents	S	
	_	3 (shortness of breath) dx			affected, and corrective actio	n will	
		hronic Obstructive Pulmonary			address the needs of all clier	nts in	
		ort indicated client B had a			the home. Measures or		
		r Advair 1 time per day. Client			systemic changes facility p		
		led another puff. The report			place to ensure no recurren		
		the additional medication			Medication Pass observation		
	_	e client orders and client B			be conducted by the Nurse, a		
		e report indicated staff did not			nurse training conducted by t	ırıe	
		ysician orders. The report			Director of Health Services. Nurse also is implementing a	new.	
		was not an as needed			"dot" medication administration		
		port indicated client B was sent			method that gives staff a way		
	out to her physician	's office by the nurse.			check their work and enhance		
	2 ARDDS report of	on 7/21/11 for a medication			accuracy; For any Medication		
		on //21/11 for a medication 11 at 8am, indicated client B's			Errors in the future, there will		
	citoi incident //20/1	i i ai oaiii, ilidicated chent B's					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATI		(X3) DATE S	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
150		15G797	B. WING			09/12/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	1					
AWS			9029 S AMERICA ROAD LA FONTAINE, IN46940				
AVVS				LAFON	TIAINE, IN40940		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Losartan HTCZ (for	Hypertension) was not given			corrective action, which will		
	_	cause staff neglected to read			incorporate training of staff w		
		Administration Record) and			made error and staff membe		
	"staff will receive re	etraining."			who acted as buddy checker		
					when appropriate. Repeated		
	•	on 7/18/11 for a medication			errors may include disciplina action up to and including	ıy	
		16/11 at 12pm, indicated client			termination. How corrective	ا م	
		r on 7/7/11. A new medication			actions will be monitored to		
		me daily was started and the ued the Lasix medication. The			ensure no recurrence The		
		m 7/7/11 through 7/17/11 client			Nurse oversees Health Care		
	•	k med and no Losartan			Monitoring of staff and provide	les	
	medication.	and no Losartan			training on medication		
	medication.				administration. The Regiona	I	
	4 There was no wr	itten BDDS report for client			Director supervises all		
		r incident documented on			professional staff, including t		
		umented. The statement			nurse, and will continue to m	eet	
		aissed three (3) doses of			with them regularly. All		
	medication because				medication errors result in		
		ll and was waiting for			Incident Reports. The new		
	authorization. No in	formation in regards to the			Incident Oversight Committe meet weekly to ensure that	e wiii	
	type of medication	which was being ordered for			adequate corrective action is		
	client C was availab	ole for review.			taken if a medication error		
					occurs. Staff disciplinary acti	on is	
		n, the QMRP (Qualified Mental			conducted by the House		
		ional) indicated client C			Manager.		
		of her Cogentin medication (for			J		
		notropic medications) because					
		make sure the pharmacy					
	provided the medica	ation.					
	0.0/10/11						
		am, an interview with the Site					
		completed. The SD indicated					
	-	nave documentation that they					
		cations not being administered ian orders and documented					
		o the incidents. The SD					
	-	y had had three (3) different					
		e 5/2011. The SD indicated the					
		ible for ensuring nursing was					
	Cillaas respons	•					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE S	3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPLETED	
		15G797	B. WING			09/12/2011	
				STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		I		AMERICA ROAD		
AWS					TAINE, IN46940		
	CLD O A A DV C	TATEMENT OF DEPICIENCIES					(3/5)
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE DEDCEDED BY FULL)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			EFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG			 	IAG	DEFICIENCE,		DATE
		ents. The SD stated the roup home had a "discussion"					
		e meeting in regards to the					
	medication errors.	t meeting in regards to the					
	modication circls.						
	Client B's record wa	s reviewed on 9/8/11 at					
	2:15pm and on 9/9/1	11 at 8:30am. Client B's					
		rders" indicated "Losartan					
	HCTZ (for Hyperter	nsion)" was ordered by her					
		Client B's 8/3/11 "Physician					
		e had a diagnosis of					
	"Hypertension."						
	Client Clement and are						
		s reviewed on 9/8/11 at 3pm. hysician Orders" indicated					
		received "Cogentin (for side					
		chotropic medications) 1mg					
	(milligram)."	enotropic inedications) ring					
	(IIIII giwiii).						
	1.1-3-6(a)						
	. ,						
W9999							
			W99	99	W 9999 State Requirements	for	10/12/2011
	State Findings				Governing Body & 24-hour		
					Incident Reporting Requirem	ent	
	431 IAC 1.1-3-1 Go	verning body		- 1	Corrective action for		
			1		resident(s) found to have be affected All professional staff		
		dential provider shall report			members who are responsible		
	•	nstances to the division by an the first business day	1		Incident Reporting will be train		
		-	1		on Agency Policy that require		
	followed by written summaries as requested by the division. This state rule was not met as evidenced by:			- 1	incident reports be completed		
				- 1	within 24 hours. How facili		
			1		will identify other residents		
		· · · · · · · · · · · · · · · · · · ·	1		potentially affected & what		
	Based on record rev	iew and interview, the facility	1		measures taken All residents		
		ediately to the facility's	1		affected, and measures taker		
	Administrator, and t	o the Bureau of		- 1	address the needs of all clier	its in	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UFRV11 Facility ID: 012563

If continuation sheet

Page 54 of 56

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPLETED	
		15G797	A. BUII			09/12/20	011
			B. WIN		PDDEGG CHTV GTATE TIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
				1	AMERICA ROAD		
AWS				LAFON	ITAINE, IN46940		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	<u> </u>	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	Developmental Disa	abilities Services (BDDS)			the home. Measures or		
	within 24 hours as r	required by law for 4 of 4			systemic changes facility p	ut in	
	medication error rep	port incidents for clients B and			place to ensure no recurrer	ice	
	C.				Training of Professional Staft	·.	
					Also, an Incident Oversight		
	Findings include:				Committee will be establishe		
					consisting of the agency's Vi		
		S (Bureau of Developmental			President, Regional Director,	and	
		reports from 7/1/11 through			Compliance Officer. This		
		ed on 9/7/11 at 11:20am and			committee will hold a documented weekly meeting	,	
	indicated the follow	ring for documented			which all Incident Reports from		
	medication errors:				the previous week are review		
	1 A DDDC -	0/1/11 1: /:			for multiple requirements,	/	
	*	on 8/1/11 medication error			including the 24-hour criterio	n.	
		4pm, indicated client B B (shortness of breath) dx			How corrective actions will		
		Thronic Obstructive Pulmonary			monitored to ensure no		
	, -	ort indicated client B had a			recurrence The Incident		
		r Advair 1 time per day. Client			Oversight Committee is Chai	red	
		ded another puff. The report			by the Compliance Officer wl	no is	
		the additional medication			operationally and		
	_	e client orders and client B			programmatically distinct from		
	_	e report indicated staff did not			facility. The Chair will ensure		
		ysician orders. The report			smooth and continuous oper	ation	
		r was not an as needed			of the committee.		
	medication. The rep	port indicated client B was sent					
		's office by the nurse.					
	-	on 7/21/11 for a medication					
		11 at 8am, indicated client B's					
	,	r Hypertension) was not given					
		cause staff neglected to read					
	MAR (Medication Administration Record) and						
	"staff will receive re	etraining."					
	1 A DDDC	7/10/11 6					
		on 7/18/11 for a medication					
		16/11 at 12pm, indicated client					
		r on 7/7/11. A new medication					
		me daily was started and the					
	physician discontini	ued the Lasix medication. The					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G797			A. BUILDING	00	COMPLETED	
		15G797	B. WING		09/12/2011	
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	NO VIDEN ON DOLLER			AMERICA ROAD		
AWS			LA FON	NTAINE, IN46940		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	*	m 7/7/11 through 7/17/11 client				
		med and no Losartan				
	medication.					
	4 There was no wr	itten BDDS report for client				
		incident documented on				
		imented. The statement				
		issed three (3) doses of				
	medication because	-				
		ll and was waiting for				
		formation in regards to the which was being ordered for				
	client C was availab					
	chefit & was availab	ic for review.				
	On 9/9/11 at 9:11am	n, the QMRP (Qualified Mental				
	Retardation Professi	ional) indicated client C				
		of her Cogentin medication (for				
		notropic medications) because				
		make sure the pharmacy				
	provided the medica	ition.				
	On 9/9/11 at 3:35pm	n, an interview with the Site				
		ompleted. The SD indicated				
		mmediately report medication				
	errors to the adminis	strator and to BDDS in				
	accordance with stat	te law.				
	1 1 2 1/b)(5)					
	1.1-3-1(b)(5)					